TESTIMONY IS EMBARGOED UNTIL 9:00 AM THURSDAY, MARCH 29, 2012

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Committee on Ways and Means, Health Subcommittee
Hearing on the Individual and Employer Mandates

March 29, 2012

Mr. Chairman and Members of the Committee, I appreciate the opportunity to testify today regarding some research that Dr. Steven A. Nyce of Towers Watson, the human resources consulting firm, and I have developed recently. We undertook this work at the request of the Council for Affordable Health Coverage, an organization comprised of associations, employers and individuals concerned about the cost of health coverage here in the United States.

Summary

Most Americans are painfully aware that their health care premiums are rising faster than other necessities of life. Many also know that their earnings are growing slowly or not at all, despite apparent increases in worker productivity. Both of these problems have been widely reported, but are seldom linked even though they are directly connected. Workers' inability to get ahead in recent years is largely attributable to growing health care costs. The analysis that Dr. Nyce and I have developed suggests that if we do not get health inflation under control, the situation will get progressively worse. Because health reform has the potential to increase the demand for health care services, it could exacerbate an already bad situation and have significant adverse consequences for workers' job and income prospects.

Employers compensate workers with cash wages, by paying a share of the payroll tax to support Social Security and Medicare, and by sponsoring and financing a substantial share of the costs of employee benefit plans. A large share of the cost of benefits for many employers is tied to the cost of sponsoring health benefit plans. Health benefit plan costs are unique among the elements of compensation paid to workers in that they are more a fixed cost than the others. The cost an employer incurs in providing health insurance to a $25,000 a year worker is essentially the same as that for providing health insurance to one earning $150,000 per year. Because of that, the health benefit component of compensation is a much larger share of the remuneration

paid to lower earners than to higher ones. Because health inflation has driven employers' health benefit costs much more rapidly than worker productivity in recent years, these benefits are eroding what is paid to workers in cash. For a worker earning around $25,000 today, the average health benefit financed by employers is roughly one-third of their pay. If this worker's contribution to a firm increases by $300 this year because of improved productivity but employer's the cost of providing health insurance increases by $450, then there is no money left to increase the amount going into the pay envelop. If some other aspect of compensation cannot be reduced, there is the potential that this worker is no longer economically viable for employment in the firm.

Under the 2010 Affordable Care Act, many employers will be required to provide workers with health insurance or to pay a penalty for not doing so. This means that the extremely important fixed-cost component of compensation will be imposed on these employers. The analysis that follows strongly suggests that the outcome will be that the problem of slow growing earnings levels will be considerably exacerbated in the future. If employers have little flexibility in making offsetting adjustments to other elements of the compensation package, it will mean some workers will find it increasingly difficult to find and keep jobs. The most vulnerable to these risk exposures are the workers at the bottom of the earnings distribution. The cost of health care, however, has gotten so high that this risk is spilling up the economic ladder more quickly than most people realize. Richard Foster, the chief actuary at the Centers for Medicare and Medicaid Services, has estimated that the Affordable Care Act will increase total health care expenditures relative to prior law by 0.9 percent of GDP by 2019.[1] We have to

[1] Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act," as Amended (April 22, 2010), Table 5, found at: http://burgess.house.gov/UploadedFiles/4-22-2010_-_OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf.

consider that there is some significant risk that health reform will increase the rate at which inflation is eroding workers' economic advancement opportunities.

Background

According to data developed by the Office of the Actuary at the Social Security Administration, workers across the U.S. economy were rewarded 66 percent of their output per hour as compensation in 1950. In 1970, they were rewarded at 67 percent of their output per hour. In 1990, the reward rate was 64 percent of their product per hour and in 2008, it was 64 percent.[2] Economists generally consider compensation to include both the cash paid to workers for their contributions in the workplace and also the benefits that employers finance in accordance with the legal requirements to make payroll tax contributions and the financing of health, retirement and other benefits provided to workers.

While total compensation paid to workers has remained a relatively constant share of total economic productivity in the United States over the period since the end of World War II, the structure of compensation has changed steadily and considerably over the period as shown in Table 1. In 1950, nearly 95 cents of every dollar of compensation was in the pay envelop. By 2010, only 80 percent of compensation was paid in cash. The "other benefits" component of Table 1 is almost completely attributable to employer contributions for their health benefit and retirement programs.

The information in Table 1 only hints at the important dynamics that have been playing out in recent decades. In order to dig deeper, we looked at what has been happening to full-time, full-year workers at various points in the earnings spectrum over the decades of the 1980s,

[2] Unpublished data from the Office of the Actuary, Social Security Administration based on data derived from the U.S. Department of Commerce, Bureau of Economic Analysis, *National Income and Product Accounts* and the U.S. Department of Labor, Bureau of Labor Statistics, *Current Employment Statistics*.

1990s, and the first decade of the new millennium. When we developed the analysis, we only had data through 2009. We hope to update the analysis in the next couple of months to include 2010. We do not believe the story will change to any significant degree in adding another year.

Table 1: Shares of Compensation Paid in Designated Forms for Selected Years

	1950	1970	1990	2010
Cash pay	94.8%	89.4%	82.4%	80.1%
Employer contributions for				
Payroll taxes	2.2	3.9	6.2	6.0
Other benefits	3.0	6.8	11.4	13.9

Source: Developed from the U.S. Department of Commerce, Bureau of Economic Analysis, *National Income and Product Accounts.*

Figure 1 shows the compound annual growth rates in inflation-adjusted average hourly pay rates across 10 comparably-sized pay groups—we call them deciles—from 1980 to 1990, 1990 to 2000, and 2000 to 2009 for full-time, full-year workers.[3] Splitting the workforce in this fashion allows us to assess how compensation and its various components grew or failed to do so at various points in the earnings spectrum and over time.[4] The results in Figure 1 make it clear that different segments of the workforce have had considerably different experiences in recent decades. Figure 1 helps to explain why some people feel they are being left behind.

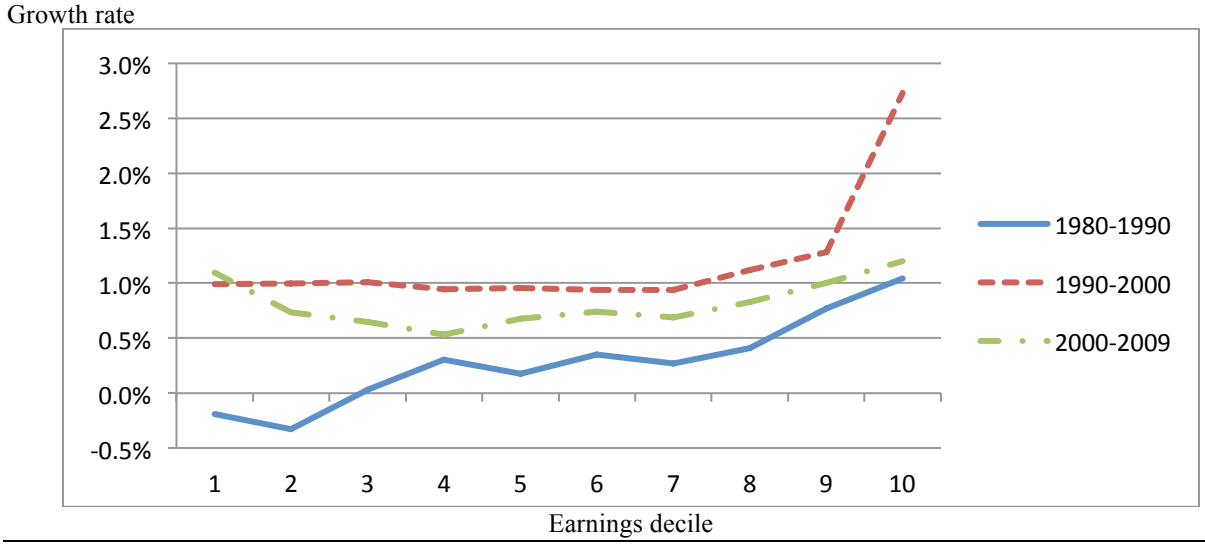
During the 1980s, there was negative wage growth for low earners, modest but flat growth across the middle-income segments and progressively higher growth across the top 30 percent of the distribution. This was a decade that started with a hard recession and the

[3] The first 9 deciles include 10 percent of the total workers being analyzed each year. The top decile includes only 9 percent of the workers because the Census Bureau does not release the income data for people in their *Current Population Survey* with incomes above a certain level. We needed the reported income data to estimate total compensation and the shares being spent on the non-wage components.

[4] The data in Table 1 run through 2010 but at the time we developed the analysis, the *Current Population Survey* data from the Census Bureau only gave us earnings data through 2009. That is the reason Figure 1 and subsequent figures only go through 2009.

elimination of many manufacturing jobs. During the decade, there was a realignment of economic activity as global competition intensified. This was the period when virtually all analyses of the pay and income dispersion phenomenon agree that the growth in rewards was disproportionately concentrated toward the upper end of the earnings spectrum. In the 1990s there was significant wage growth across all earnings categories—but wages still grew considerably more at the top income levels. During this period, many middle and upper-level managers in private firms were included in pay-for-performance plans and, with rapid economic growth during the mid to late-1990s, earners at the top of the distribution did disproportionately well. The rate of growth in pay clearly fell back during the 2000s and was not as flat across the earnings distribution as during the 1990s.

Figure 1: Compound Annual Growth Rates of Inflation-Adjusted Hourly Pay for Full-Time, Full-Year Workers by Earnings Decile and for Selected Periods

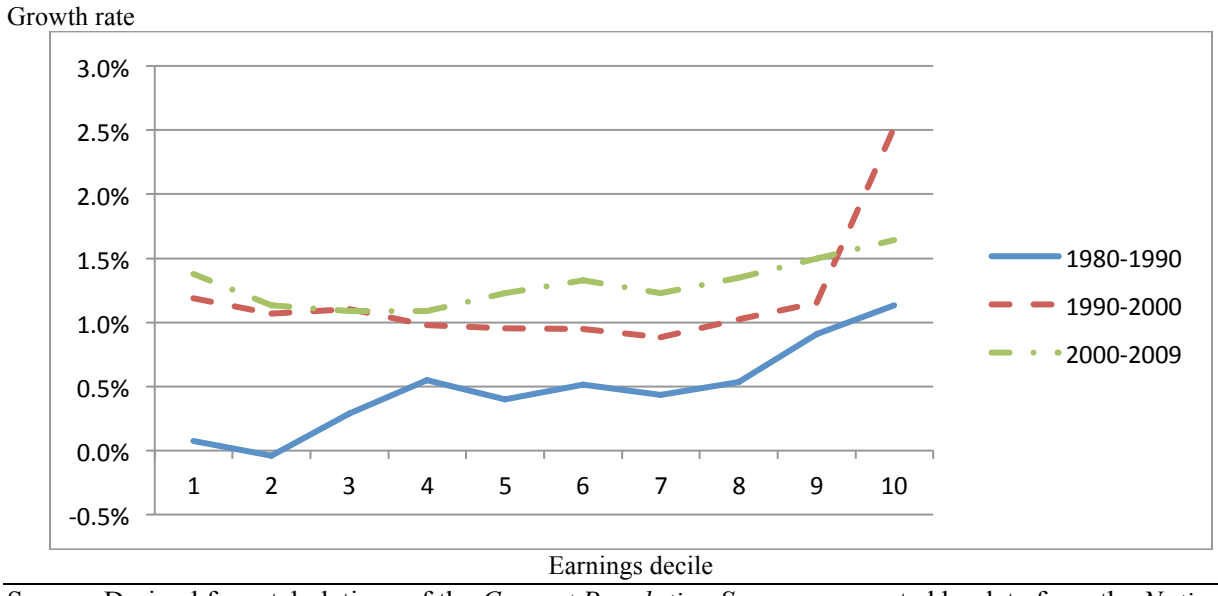


Source: Derived from tabulations of the *Current Population Survey*, various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

Figure 1 helps to explain why some segments of the workforce feel they are not doing as well as others but is incomplete. In Figure 2, employer costs for retirement plans, including

employers' plans and social insurance benefits, as well as for employers' health plans are added to cash pay. While wage growth in the 2000s fell short of that achieved during the 1990s, there was more compensation growth across most of the earnings spectrum in the early 2000s than in either of the prior two decades. Figure 2 suggests that workers across the earnings spectrum have benefited from added productivity in recent years at least in terms of what employers are paying them in reward for their work contributions. Those in the eighth earnings decile and above did somewhat better than those at lower levels, but generally workers did much better than the cash-only perspective suggests. If workers in middle and lower earnings levels feel they are not partaking of the rewards for their work contributions, given the results in Figure 2, it suggests they either do not understand the value of contributions made to benefit programs or simply do not value the benefits being provided by employers in relation to the cost of these programs.

Figure 2: Compound Annual Growth Rates of Inflation-Adjusted Hourly Compensation for Full-Time, Full-Year Workers by Earnings Decile and for Selected Periods



Source: Derived from tabulations of the *Current Population Survey* augmented by data from the *National Income and Product Accounts* for various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

One explanation for why workers might not appreciate the value of the contributions that employers are making to their benefit programs is that most of employers' contributions for payroll taxes and employee benefit programs are out of the line of sight of workers. Some employers give workers total compensation statements each year delineating the cost of benefits being provided but even that is not the same as providing a regular paystub with deductions indicating the costs of benefits. Without the line of sight, workers have little clue about the costs involved and thee effect on take-home pay. They may appreciate even less how their positioning in the earnings distribution affects the relative costs of benefits that employers are providing.

Payroll taxes and employer contributions tend to be a relatively comparable share of wages for workers across the bottom eight or nine earnings deciles and trail off somewhat at very high earnings levels because of the cap on earnings for the Social Security payroll tax and income-tax limits on what can be contributed to retirement plans for the highly compensated. Health insurance provided by employers tends to have a different cost structure across the earnings spectrum than other significant benefits. Consider, for example, where an employer is providing health insurance costing $10,000 per worker on average, of which only $2,500 is covered by direct employee contributions and the remaining $7,500 is a compensation cost that applies to each worker regardless of pay level. For the worker earning $20,000 per year, this benefit equals 37.5 percent of cash wages but for the $200,000 worker, it is only 3.75 percent of wages. If employers' health insurance costs are growing faster than workers' productivity, which they have been doing for the last several decades, and this is eroding wages, it will naturally have a much larger effect on low earners than high ones because health benefits make up so much more of lower earners' total compensation. Because of that, health benefits have the potential to make certain workers uneconomical in some cases.

When benefit costs grow more rapidly than the compensation budget, wage growth is reduced. The growing share of compensation diverted to benefits, shown in Table 2, explains some of the public consternation about what has been happening to disposable earnings. The sluggish growth in disposable income has been attributed to a variety of causes, including changing reward structures in the corporate world and tax policy as the focus of many commentaries. Those factors may have played some role in developments, but growing benefit costs were likely a much larger reason for the unsatisfactory results many people have had at the pay window in recent years. The underlying factors that have affected the non-wage components of compensation over the past three decades have not played themselves out, so these forces will have a continuing role in the future rewards picture.

Table 2: Share of Compensation Gains Provided in the Form of More Expensive Benefits Paid by Employers for Full-Year Workers by Earnings Decile and for Selected Periods[*]

Earnings decile	1980-1990[*]	1990-2000	2000-2009
1	100.0%	30.4%	35.2%
2	100.0%	23.1%	47.7%
3	90.8%	25.0%	52.3%
4	54.1%	21.3%	60.8%
5	63.9%	17.8%	55.7%
6	43.0%	18.8%	55.3%
7	48.6%	12.4%	54.8%
8	36.8%	9.6%	50.3%
9	29.7%	7.8%	45.0%
10	21.4%	6.8%	37.7%

Source: Derived from tabulations of the *Current Population Survey* augmented by data from the *National Income and Product Accounts* for various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

[*]Total benefit cost increases in the 1980s for the first and second earnings decile exceeded 100 percent of compensation growth. In both cases, benefit costs increased significantly, but total compensation growth was in the negligible first decile and negative in the second.

Health Care Inflation and Workers' Pay

In the 1980s, increases in payroll tax rates arose as the 1977 and 1983 Social Security Amendments dealing with the financing problems of that era took effect. By the 1990s, those were relatively absorbed. Employer contributions for their retirement plans actually declined as a percentage of compensation over the 1980s and 1990s partly in response to regulatory changes but also because of the bullish financial market results we enjoyed in that period. In the early years of this century, employers have had to make significantly higher contributions to retirement plans and that is retarding wage growth. In every decade though, growing health costs have been a major factor in slowing the growth of dollars in the pay envelop.

Table 3 shows the share of increasing compensation that has been diverted to increased employer contributions for health benefit programs over each of the past three decades. Note that the share of compensation that was diverted to health benefits includes all full-time, full-year workers at each earnings level, including those who did not receive health benefits from their own employers.

For the workers actually covered by their own employers' health benefit plans, the implications were even more severe than the table suggests. Declining coverage, which has tended to be concentrated among lower-wage workers, actually mitigated some of the "crowding out" effect shown in Table 3 in recent years. But workers who lost employer-provided health insurance had to spend more out of pocket for their own health care consumption. It is a classic case of "damned if you do and damned if you don't."

Keep in mind that the primary purpose of this analysis was to explain how health care cost inflation undercuts the general rewards for broad groups of the workforce. However, rising health costs also affect employers' hiring decisions. In considering whether to keep or add a

worker, employers focus on the narrow question of what that worker will cost compared to the value he or she will bring to the organization. In economic terms, the marginal costs of workers in the various earnings deciles who actually take health insurance are quite different from the average costs of all workers in the deciles.

Table 3: Share of Compensation Gains Provided in the Form of More Expensive Health Benefits Paid by Employers for Full-Year Workers by Earnings Decile and for Selected Periods*

Earnings decile	1980-1990*	1990-2000	2000-2009
1	100.0%	26.8%	23.6%
2	100.0%	20.8%	30.4%
3	100.0%	23.6%	30.1%
4	57.2%	21.0%	36.5%
5	74.4%	19.8%	28.9%
6	45.2%	22.5%	26.7%
7	55.5%	15.5%	25.8%
8	38.7%	12.1%	20.1%
9	21.4%	9.1%	15.0%
10	12.1%	2.9%	9.1%

Source: Derived from tabulations of the *Current Population Survey* augmented by data from the *National Income and Product Accounts* for various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

*Health benefit cost increases in the 1980s for the bottom three earnings deciles exceeded 100 percent of compensation growth.

As noted earlier, health insurance provided by employers tends to have a different cost structure across the earnings spectrum than other significant benefits. Health insurance benefits taken by the clerical person earning $8 per hour in a company creates a cost roughly equivalent to the benefit provided to a worker earning 10 or 20 times that amount or more. In this regard, employers' health benefits costs tend to be much more in the nature of fixed costs for the workers who participate in such plans. Because of that, health benefits have the potential to make certain workers uneconomical in some cases.

Table 4 shows how health benefit costs have risen relative to wages between 1980 and 2009 for workers who actually enrolled in the health benefit plans offered by their employers. In 1980, employers' costs for such workers were in single digits relative to wages for all decile groups except the lowest, with the median enrolled employee costing about six percent of pay. Over the next three decades, those costs have grown more than threefold relative to wages, reaching more than a third of individuals' wages among the lowest decile groups. In fact, for the lowest decile group, health costs have nearly eclipsed half of employees' take-home pay in 2009. What's more, these costs have been growing at a much faster pace for the lowest-paid workers, highlighting the greater impact of compounding on the lower-pay groups. For example, health benefit costs relative to wages for the second decile were twice those for workers in the ninth decile in 1980 and three times more by 2009. In short, the escalating cost of health care benefits may price low-wage workers out of labor markets.

Table 4: Health Benefit Costs as a Share of Wages for Full-Time, Full-Year Workers Receiving Health Care Benefits through Their Employer

	1980	1990	2000	2009
1	15.4%	30.9%	38.1%	49.5%
2	9.5%	18.7%	22.9%	30.9%
3	8.0%	15.3%	18.6%	25.5%
4	7.2%	13.3%	16.0%	22.3%
5	6.3%	11.6%	14.0%	19.4%
6	5.8%	9.9%	12.1%	16.8%
7	5.4%	9.2%	10.8%	14.8%
8	4.9%	8.2%	9.2%	12.5%
9	4.3%	6.9%	7.8%	10.2%
10	3.2%	4.9%	4.7%	6.3%

Source: Derived from tabulations of the *Current Population Survey* augmented by data from the *National Income and Product Accounts* for various years as described in Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

The Past as Prologue

The future growth of compensation components that siphon rewards out of workers' paychecks will depend on a variety of factors. If the employer-based pension and retirement savings programs continue to operate at current levels, contributions to the systems should moderate considerably in the next four or five years once remaining unfunded pension liabilities are covered by added contributions required under the Pension Protection Act of 2006. What happens to the payroll tax will depend on how Social Security and Medicare financing shortfalls are addressed. If most of the underfinancing in these programs is addressed through higher tax rates, the adjustments of our retirement systems will make a further claim of workers compensation and dampen earnings growth. If much of the financing shortfall is addressed by increasing earnings subject to taxation, the effects will be concentrated at higher earnings levels. What happens to the payroll tax in coming years will be extremely important, but the real wild card in this deck is what happens to health costs. The implications will likely be quite significant.

The reason health care is such a wild card in the compensation and employment outlook is because no one really knows what the implications of health reform will be on health costs over the next decade or two. The last time the federal government intruded on the health financing system by introducing a major new national program was in the mid-1960s when Medicare was implemented. There was not much to go on then either in terms of estimating what costs would be under the program. In the decade prior to the adoption of the Medicare Part A (Hospital Insurance [HI]) program, hospital costs had been rising about three percentage points faster per year than covered wages.[5] The Advisory Council on Social Security Financing

[5] Robert J. Myers, actuary to the Committee on Ways and Means, "Actuarial cost estimates and summary of provisions of the Old-Age, Survivors and Disability Insurance Systems as modified by the Social Security Amendments of 1965 and actuarial cost estimates and summary of provisions of the Hospital Insurance and

met during 1963 and 1964 to consider these trends and determine what assumption to use in projecting the new HI program costs. The advisory council proposed assumptions for the initial projections: Hospital costs would rise 2.7 percent more than wages over the first five years of the program's operations, then trend down to the wage growth rate over the next five years and for all subsequent years.[6] As it turned out, over the first quarter century of the Medicare HI program's operations, the average covered wage subject to the payroll tax grew at an average compound rate of 6.2 percent per year, while average daily hospital costs rose at a compound rate of 11.9 percent per year. Over the last 10 years of that period—when it was "conservatively" assumed that hospital costs would grow at the same rate as wages—the growth rate in daily hospital costs was outpacing wage growth by 4.5 percentage points per year.[7]

A second major variable in determining actual HI cost rates was the hospital utilization rate. Estimated utilization rates were based on the 1957 Survey of Beneficiaries conducted by the Social Security Administration.[8] In making the projections, Robert Myers argued that utilization rates were most likely to conform to a "low-cost estimate," at least during the early years of the program, "to give recognition to the possibility of success of current efforts for progressive patient care, for reductions in hospitalization costs resulting from development of outpatient hospital diagnostic facilities and for progressive cost-reducing trends in medical practice."[9] In the final cost projections, the Ways and Means Committee of the House of

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Supplementary Medical Insurance Systems as established by such act" (Committee on Ways and Means, House of Representatives, 89th Congress, First Session, July 1965).

[6] Ibid. p. 28.

[7] Average wages were calculated from the Average Wage Index series developed by the Office of the Actuary, Social Security Administration; average daily hospital charges and reimbursement rates were taken from the *Social Security Bulletin Annual Statistical Supplement, 1976,* p. 178, *Social Security Bulletin Annual Statistical Supplement, 1981*, p. 209, and *Social Security Bulletin Annual Statistical Supplement, 1993*, p. 311.

[8] Robert J. Myers, "Actuarial Cost Estimates for Hospital Insurance Act of 1965 and Social Security Amendments of 1965," Actuarial Study No. 59 (U.S. Department of Health, Education and Welfare, Social Security Administration, Division of the Actuary, January 1965), p. 7.

[9] Ibid, p. 8.

Representatives had Myers use higher utilization rates than those used for his original estimates. The increase in the early-year utilization assumption was about 20 percent under the more conservative assumptions. The use of the high-cost utilization rates in later years was considered a safety factor. As the program was implemented, over the first 17 years or so, utilization levels consistently ran some 20 percent higher than even the more conservative Ways and Means Committee assumptions. The estimates that had been repeatedly characterized as "conservative" turned out to be excessively optimistic.

In addition to higher than expected inflation and greater than expected utilization of services, the expanding protections offered through HI became a third contributing factor in cost inflation. In 1972, all those who had received disability benefits for 24 consecutive months under the Social Security Disability Insurance Program or the Railroad Retirement Program became eligible for coverage. At the same time, HI benefits were also made available to those younger than 65 with end-stage renal disease who were insured under Social Security or receiving an SSDI benefit. By 1975, the number of days of HI-covered care provided to this new group was approaching 10 percent of the elderly caseload. By 1983, the disabled and end-stage renal covered days of care under the HI program were 16 percent of the elderly caseload.

The underestimated costs for Medicare's HI program were not simply additive—they compounded each other. If reality had lived down to expectations, the cost of the HI program in 1990 would have been less than half of what it was. Health cost inflation stretched well beyond the financing of Medicare. It also affected the cost of health insurance benefits that employers were providing to workers.

It is interesting to juxtapose the expectations on the costs of implementing the Affordable Care Act with those that prevailed by prominent policymakers and analysts involved in the

development and implementation of Medicare several decades ago. Peter Orszag, former director of the Office of Management and Budget and a major architect of the Affordable Care Act, and Ezekiel Emanuel, special advisor to the White House and OMB during its development, have predicted that under the new law, total health expenditures in the United States in 2030 will be only 0.50 percent less as a share of GDP than under prior law.[10] Against a pre-reform estimate by the Congressional Budget Office that health care spending would rise from around 17.5 percent of GDP in 2009 to 29 percent of GDP in 2030,[11] an anticipated saving of 0.5 percent of GDP does not suggest substantial relief from excessive medical cost inflation.

Not everyone agrees with the assessment that the Affordable Care Act will operate as its architects suggest it will if fully implemented. Richard Foster, the chief actuary at the Centers for Medicare and Medicaid Services, estimated that the Affordable Care Act would actually increase total health care expenditures by 0.9 percent of GDP by 2019.[12] Tracking through Foster's analysis in the memo that includes the estimate that health expenditures will expand over the remainder of this decade under health reform, he estimated that expenditures under employer-sponsored health plans would climb from $847.0 billion in 2010 and $1,387.3 billion in 2019. Foster's projections of expenditures under employer-sponsored private health insurance suggests that the cost of health benefits in 2019 would be 3.7 percent lower under the reform measure than prior law.[13] Before concluding that this might be a sliver of sunshine in this story, we need to keep in mind that the base projection was that there would be 64 percent growth in employer plan costs so CMS projects that will fall to only 60 percent. Furthermore, even the

[10] Peter R. Orszag and Ezekiel J. Emanuel, "Health Care Reform and Cost Control," *New England Journal of Medicine* (June 16, 2010), found at: http://healthpolicyandreform.nejm.org/?p=3564.

[11] Congressional Budget Office, *The Long-Term Outlook for Health Care Spending* (2007), p. 13, found at: http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf.

[12] Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act," as Amended (April 22, 2010), Table 5, found at: http://burgess.house.gov/UploadedFiles/4-22-2010_-_OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf.

[13] Ibid.

actuaries at CMS believe there will be a slight decline in the number of workers covered under employer-sponsored health benefits by 2019.[14] In other words, if the CMS actuaries' estimates are correct, health reform will provide virtually no relief to the cost pressures that were expected under current law for those receiving benefits under these plans.

So what does this outlook and evidence and evidence supporting it suggest for our future? Major policy changes that expand insurance coverage of large segments of the population and that change financing incentives, payment mechanisms and the like will almost certainly affect health care pricing and utilization patterns. We ignore at our peril the possibility that the new health reform law will turn out to have a set of unanticipated costs similar to Medicare, especially when we consider that the new law's major proponents and architects admit we will have to re-engineer the delivery system to create the sort of cost savings they anticipate. Since health care insurance financing is such an important element of the compensation package the majority of workers receive, health reform will likely continue to play a central role in determining workers' employment and wage outcomes.

Looking Ahead

Employers' rising health costs can be offset by cutting other parts of the total compensation package. But workers' cash pay tends to be sticky downward—meaning that it is difficult to reduce pay without causing disruptions among their workforces that most employers try to avoid. If employers are forced to absorb health cost increases that exceed the added productivity that workers bring to the table, they will stop hiring.

No one knows for certain what the implications of the Affordable Care Act, might be for U.S. workers in terms of their future health costs—or even how they will acquire their health

[14] Ibid., based on a data from Table 5 of the analysis.

insurance coverage in the coming years. Our analysis makes clear, however, that, if we cannot bring excessive health care inflation under control, wages will continue to stagnate, and low-wage workers will find it harder to find work. We must recognize the possible risk that we could exacerbate an already troubling situation.

A full-time worker in the second earnings decile in 2009 earned around $25,000 in total compensation on average. If his or her productivity goes up by the rate of growth Social Security actuaries estimate, by 2019 this worker will be earning around $36,600 in total compensation. But here's the rub: nearly 75 percent of the gain will have been consumed by rising health benefit costs. If the worker has family coverage, the cost of health benefits will grow to consume more than his or her added productivity improvement over the period.

Let's assume that future health costs grow at the rate they have been growing since 2000. In keeping with assumptions by the Congressional Budget Office and the Obama Administration that employers will not cut back their coverage under health reform, let's further assume that current health insurance coverage and take-up rates persist. Table 5 projects the results: Health benefits will cut even more deeply into compensation than over the past couple of decades. If employer-provided health insurance coverage expands because of the mandates under health reform, or if inflation rises because of added demand for services or any other reason, the outcome could be even worse than Table 5 suggests. The reason for this conclusion is that we are now starting from a much larger base of health costs under these benefit plans than we had 20 or 30 years ago. In 1980, employer contributions for health benefit plans were only 3.8 percent of total compensation paid to workers. By 2010, they had risen to 9.0 percent. Excessive health inflation that we have been experiencing and may well experience in the future now applies to a much larger share of compensation than it has in the past.

Table 5: Share of Compensation Gains Provided in the Form of More Expensive Health Benefits Paid by Employers for Full-Year Workers by Earnings Decile and for Selected Periods Where Health Cost Inflation Persists at Current Rates and Coverage and Take-Up Rates Remain at Current Levels

Earnings decile	Projection periods: 2009 to 2015	2015 to 2030	2009 to 2030
All	24.9%	35.0%	32.4%
1	39.1%	54.9%	50.9%
2	38.4%	54.0%	50.1%
3	38.5%	54.2%	50.2%
4	38.3%	53.9%	49.9%
5	35.1%	49.3%	45.7%
6	33.1%	46.6%	43.2%
7	29.9%	42.0%	38.9%
8	26.2%	36.9%	34.2%
9	21.8%	30.7%	28.5%
10	13.9%	19.5%	18.0%

Source: Steven A. Nyce and Sylvester J. Schieber, "Healing Our Ills and Killing Our Prospects," June 29, 2011 found at: http://www.cahc.net/2011/07/new-cahc-study-health-costs-are-killing.html.

For workers participating in their employer plans, the cost issues are much worse than the averages for all workers suggest. For those in their employers' health benefit plans in 1980, the employers' costs of providing them health benefits was equivalent to 7 percent of their wages but this rose to 21 percent in 2009. For workers in the second decile with coverage, the cost of health benefits being taken rose from just under 10 percent of their pay in 1980 to 31 percent in 2009. The implications of excessive health inflation become stark for such workers.

Consider the case of a worker whose productivity warrants a compensation level of $30,000 per year. Ignoring the effects of potential increases in payroll taxes to address Social Security and Medicare funding issues and other unanticipated factors, assume that this worker is receiving $10,000 in the form of health benefits because he or she has family coverage under the

employer's plan. If this worker's productivity increases 1.5 percent next year, it would warrant an increase of $450 in compensation. If health benefit costs go up by 4.5 percent next year, then all of this worker's productivity reward would be scalped off to cover the higher health benefit costs. Among workers with health insurance coverage, the cost of these benefits has been increasing about 3 percentage points faster per year in recent years than productivity improvement rates.

This ugly arithmetic suggests that employers cannot offer such workers both health benefits and growing wages, and hope to remain competitive in a global economy. The employer mandate to provide health insurance coverage may be an admirable goal from the sole perspective of getting more people health insurance but it has the potential to create a straightjacket for employers continuing to offer health benefits in regard to being able to economically afford to hire lower-wage workers. The only safety valve that employers with predominantly lower-wage workers may have is simply to abandon offering health insurance because the federal subsidies for workers who acquire insurance in exchanges under the Affordable Care Act rather than from their employers could dramatically change the economics of health care. While some policy analysts believe that most employers will stay in the game of offering health benefits to their workers, the analysis presented here leads me to conclude that many employers, particularly in low-wage industries, will likely eliminate their plans and let workers fend for themselves in the new exchanges because the economics employing low earners simply doesn't work at current cost and inflation levels.

At the margin, shifting an ever larger share of low earners into publicly subsidized health care insurance programs might seem desirable but we cannot avoid the reality of a national health care marketplace. The mere shifting of health insurance costs -- from employers'

compensation packages to a mix of public subsidy and workers' contributions out of their disposable wages -- will not reduce national health care spending unless we bring medical inflation under control. If health reform is not expected to bend down the curve of health cost growth, who is going to pay the bill?